FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027581

Facility Name: MANORCARE AT CHAMPAIGN

Address: 309 E. Springfield (Number) Champaign (City) 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 352-5135 **Fax #** (217) 352-9139

IDPA ID Number: 520886946008

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/01 to 05/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	350	4,844	5,194	8
9	SNF/PED					9
10	ICF	15,605	11,957	536	28,098	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,605	12,307	5,380	33,292	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

D. How many bed-hold days during this year were paid by Public Aid?
142 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 4,490

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/02 Fiscal Year: 05/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	179,586	10,082	15,059	204,727	1,165	205,892		205,892			1
2	Food Purchase		132,973		132,973		132,973	(2,816)	130,157			2
3	Housekeeping	86,208	14,480	2,920	103,608	70	103,678		103,678			3
4	Laundry	35,673	14,099	2,258	52,030		52,030		52,030			4
5	Heat and Other Utilities			94,958	94,958	5,541	100,499		100,499			5
6	Maintenance	34,495	34,881	46,194	115,570		115,570		115,570			6
7	Other (specify):* Med Waste			473	473		473		473			7
8	**TOTAL General Services**	335,962	206,515	161,862	704,339	6,776	711,115	(2,816)	708,299			8
	B. Health Care and Programs											
9	Medical Director			6,800	6,800		6,800		6,800			9
10	Nursing and Medical Records	1,333,837	171,386	29,365	1,534,588	25,780	1,560,368		1,560,368			10
10a	Therapy	243,034	5,645	15,403	264,082		264,082		264,082			10a
11	Activities	88,968	13,439	5,419	107,826		107,826		107,826			11
12	Social Services	48,862	474	1,082	50,418		50,418		50,418			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,714,701	190,944	58,069	1,963,714	25,780	1,989,494		1,989,494			16
	C. General Administration											
17	Administrative	66,101		258,523	324,624	(107,127)	217,497		217,497			17
18	Directors Fees											18
19	Professional Services			388	388	(70)	318	(318)				19
20	Dues, Fees, Subscriptions & Promotions			48,366	48,366		48,366	(18,774)	29,592			20
21	Clerical & General Office Expenses	204,981	35,621	114,159	354,761		354,761	(48,040)	306,721			21
22	Employee Benefits & Payroll Taxes			389,166	389,166	8,576	397,742		397,742			22
23	Inservice Training & Education			5,804	5,804		5,804		5,804			23
24	Travel and Seminar			14,136	14,136		14,136		14,136			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,662	68,662		68,662		68,662			26
27	Other (specify):*											27
28	**TOTAL General Administration**	271,082	35,621	899,204	1,205,907	(98,621)	1,107,286	(67,132)	1,040,154			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,321,745	433,080	1,119,135	3,873,960	(66,065)	3,807,895	(69,948)	3,737,947			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MANORCARE AT CHAMPAIGN #0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			229,665	229,665	29,730	259,395		259,395			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,672	105,672	36,335	142,007		142,007			32
33	Real Estate Taxes			40,949	40,949		40,949	987	41,936			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,751	13,751		13,751		13,751			35
36	Other (specify):*											36
37	**TOTAL Ownership**			390,037	390,037	66,065	456,102	987	457,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,338	1,418	121,756		121,756		121,756			39
40	Barber and Beauty Shops		12,678	2,269	14,947		14,947		14,947			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*		71,158		71,158		71,158		71,158			43
44	**TOTAL Special Cost Centers**		204,174	59,532	263,706		263,706		263,706			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,321,745	637,254	1,568,704	4,527,703		4,527,703	(68,961)	4,458,742			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,816)	2		4
5	Telephone, TV & Radio in Resident Rooms	(928)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,641)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,136)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,590)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(318)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,745)	21		24
25	Fund Raising, Advertising and Promotional	(18,774)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	987	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,961)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (68,961)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Page 5A

MANORCARE AT CHAMPAIGN

ID# 0027581

Report Period Beginning: 06/01/01

Ending: 05/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,816)	0	0	0	0	0	0	0	0	0	0	(2,816)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,816)	0	0	0	0	0	0	0	0	0	0	(2,816)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(318)	0	0	0	0	0	0	0	0	0	0	(318)	19
20	Fees, Subscriptions & Promotions	(18,774)	0	0	0	0	0	0	0	0	0	0	(18,774)	20
21	Clerical & General Office Expenses	(48,040)	0	0	0	0	0	0	0	0	0	0	(48,040)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(67,132)	0	0	0	0	0	0	0	0	0	0	(67,132)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,948)	0	0	0	0	0	0	0	0	0	0	(69,948)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	987	0	0	0	0	0	0	0	0	0	0	987	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	987	0	0	0	0	0	0	0	0	0	0	987	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(68,961)	0	0	0	0	0	0	0	0	0	0	(68,961)	45

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH.			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 258,523	HCR Manor Care, Inc.	100.00%	$ 258,523	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	15,000	Heartland Management Services	100.00%	15,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 273,523			$ 273,523	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$	4,152,436	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	4,152,436	1,165	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		4,152,436	316	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		4,152,436	5,225	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	4,152,436	22,523	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	4,152,436	3,257	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	4,152,436	28,913	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	4,152,436	122,482	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		4,152,436	4,418	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		4,152,436	4,158	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		4,152,436	208	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		4,152,436	29,522	12
13										13
14	32	Interest				36,335			36,335	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 124,392,675	$ 66,939,331		$ 258,523	25

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 522,057	$ 522,057			$ 36,335	1
2	City of Champaign						619,876	621,955			83,676	2
3	City of Champaign -Debt Discount						(221,791)	(201,761)			20,030	3
4	Bank of America						280,211	280,211			1,966	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,200,353	$ 1,222,462			$ 142,007	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,200,353	$ 1,222,462			$ 142,007	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 39,962	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 40,949	2
3. Under or (over) accrual (line 2 minus line 1).		$ 987	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,949	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 41,936	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	39,764	8
	1998	40,027	9
	1999	42,028	10
	2000	39,962	11
	2001	40,949	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE AT CHAMPAIGN COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0027581

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	46-21-18-103-003	See Attached	$ 35,571.42	$ 35,571.42
2.	46-21-18-103-012	See Attached	$ 2,249.26	$ 2,249.26
3.	46-21-18-103-021	See Attached	$ 1,704.94	$ 1,704.94
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,525.62	$ 39,525.62

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,745 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1968	$ 54,050	1
2					2
3	TOTALS			$ 54,050	3

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102			1968	$ 1,201,229	$ 49,910		$ 49,910	$	$ 1,412,346	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					116,478		116,478		970,812	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1988	41,139						13
14				1989	1,297						14
15				1990	20,319						15
16				1991	50,575						16
17				1992	374,174						17
18				1993	51,354						18
19				1994	48,400						19
20				1995	229,982						20
21	ELECTRICAL WORK			1996	17,102						21
22	WALLVINYL			1996	10,548						22
23	VINYL FLOORING			1996	14,858						23
24	INSTALL CAMERA SYSTEM			1996	1,453						24
25	REMODEL 13 ROOMS AND LOBBY			1996	35,665						25
26	HVAC			1996	21,101						26
27	ROOF WORK			1996	1,365						27
28	CORPORATE OVERHEAD-13 ROOMS/LOBBY			1996	7,272						28
29	CONCRETE WORK			1996	3,880						29
30	CARPET			1996	5,900						30
31	DIGITAL KEYPAD			1996	1,915						31
32	INSTALL EMERGENCY GENERATOR			1996	44,791						32
33	INSTALL CIRCUIT BREAKER			1996	3,289						33
34	HVAC			1996	1,867						34
35	INSTALL COVE BASE/SIGNS			1996	2,612						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALLCOVERINGS	1997	$ 12,165	$		$	$	$	37
38	CARPET	1997	1,639						38
39	INSTALL HYDROLIC CYLINDER	1997	14,249						39
40	UNIT PROTECTION SWITCH	1997	6,354						40
41	FURNISH/INSTALL TILES	1997	16,476						41
42	HANDRAILS	1997	5,661						42
43	RETIREMENTS	1987	(55,068)						43
44	RETIREMENTS	1992	(6,784)						44
45	PLUMBING	1997	7,610						45
46	VINYL TILE	1997	1,643						46
47	HAND RAILS	1997	1,450						47
48	FACILITY PLAN ALLOC	1997	2,759						48
49	INSTALL GATES	1997	1,226						49
50	CORNER GUARDS	1997	314						50
51	ELECTRICAL	1998	2,598						51
52	REPLACE WINDOWS	1998	2,763						52
53	INSTALL QUARRY TILE	1998	1,640						53
54	INSTALL DUCTWORK	1998	2,350						54
55	CORPORATE OVERHEAD	1998	1,702						55
56	SECURITY SYSTEM	1998	33,542						56
57	ENTRYWAY/PARKING LOT WORK	1998	2,209						57
58	ELEVATOR EQUP EVAL	1998	700						58
59	CARPENTRY	1998	355						59
60	WALLPAPER	1998	400						60
61	CARPETING/FLOORING	1998	2,471						61
62	PLUMBING	1998	9,690						62
63	ELECTRICAL	1998	1,367						63
64	HVAC	1998	565						64
65	PAINTING/WALLCOVERING	1998	10,552						65
66	GENERAL REQ	1998	1,500						66
67	CONTRACTORS	1998	2,507						67
68	ROOFING	1998	500						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,365,666	$ 166,388		$ 166,388	$	$ 2,383,158	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,365,666	$ 166,388		$ 166,388	$	$ 2,383,158	1
2	DOOR/WINDOW	1998	2,456						2
3	ELEVATORS	1998	3,433						3
4	SIGNAGE	1998	11,862						4
5	CARPETING	1999	5,993						5
6	CALL LIGHT SYSTEM	1999	42,342						6
7	1997 BILLING FOR CONSTRUCTION	1999	20,476						7
8	INSTALL SECURE DOOR KIT	1999	3,753						8
9	FABRIC FOR PATIENT FURNITURE	1999	121						9
10	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						10
11	FABRIC FOR PATIENT FURNITURE	1999	674						11
12	PAINT, WALLPAPER, CORRIDOR	1999	8,471						12
13	FIRE-SMOKE DAMPERS	1999	(581)						13
14	REMODEL KITCHEN RECEPTACLES	1999	4,800						14
15	NEW SHOWER BASE	1999	6,870						15
16	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						16
17	CERAMIC TILE - 2 SHOWERS	1999	2,718						17
18	FIRE & SMOKE DAMPERS	1999	9,527						18
19	PROCARE 1000 NURSE CALL	1999	17,494						19
20	DRAIN REPLACEMENT	2000	875						20
21	DRYWALL REPAIR	2000	600						21
22	ZSN REPAIR	1999	1,307						22
23	CONTROL PANEL REPLACED	2000	984						23
24	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						24
25	WALLCOVERINGS	2000	364						25
26	VINYL WALLCOVERINGS	2000	1,662						26
27	WALLCOVERING	2000	1,566						27
28	CLOSET DOORS	2000	13,140						28
29	WALLCOVERING	2000	37						29
30	WALLCOVERING - DINING RM	2000	1,769						30
31	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						31
32	CORNER GUARDS	2000	17						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,537,834	$ 166,388		$ 166,388	$	$ 2,383,158	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,537,834	$ 166,388		$ 166,388	$	$ 2,383,158	1
2	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						2
3	WALLCOVERING	2000	270						3
4	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						4
5	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						5
6	VCT	2000	3,230						6
7	WIRING - ACTIVITY & REC RM	2000	1,412						7
8	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						8
9	PAINTING CLOSET DOORS	2000	8,000						9
10	SINK, FAUCET & PLUMBING	2000	1,985						10
11	ARCADIA HALL BATH	2000	3,933						11
12	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						12
13	CLOSET DOORS	2000	7,640						13
14	SHOWER-CERAMIC TILE	2000	302						14
15	CLOSET DOOR - RETAINAGE	2000	1,460						15
16	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						16
17	2 NURSE STATIONS	2001	12,826						17
18	BORDER	2001	210						18
19	VCT	2001	1,130						19
20	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						20
21	DOORS	2001	8,985						21
22	CARPET	2001	1,053						22
23	CEILING TILE	2001	28,650						23
24	SHOWER RENOVATION	2001	13,048						24
25	PAINTING	2001	765						25
26	COURTYARD RENOVATIONS	2001	4,775						26
27	COURTYARD RENOVATIONS	2001	5,120						27
28	DOORS	2002	746						28
29	CARPET	2002	995						29
30	WALL TILE FOR SHOWER	2002	1,840						30
31	MILLWORK, ELECTRICAL	2002	14,351						31
32	CARPET	2002	1,686						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,678,477	$ 166,388		$ 166,388	$	$ 2,383,158	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,678,477	$ 166,388		$ 166,388	$	$ 2,383,158	1
2	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)	(727)		(727)		(4,545)	2
3	C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)	(276)		(276)		(1,218)	3
4	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)	(170)		(170)		(681)	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,666,745	$ 165,215		$ 165,215	$	$ 2,376,714	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 580,720	$ 64,450	$ 64,450	$		$ 369,794	71
72	Current Year Purchases	170,642						72
73	Fully Depreciated Assets							73
74	H.O Allocation			29,730	29,730			74
75	TOTALS	$ 751,362	$ 64,450	$ 94,180	$ 29,730		$ 369,794	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,472,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,665	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,395	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,730	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,746,508	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 13,751 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3632	hrs	$ 86,364	236	$ 5,905	$ 1,860	3,868	$ 94,129	1
2	Licensed Speech and Language Development Therapist	10a	2757	hrs	65,559	78	1,950	151	2,835	67,660	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3831	hrs	91,111	294	7,350	3,634	4,125	102,095	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				120,154		120,154	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Inhal, Pharm,Lab	10, Col.3,39					9,861	184		10,045	13
14	TOTAL				$ 243,034	608	$ 25,066	$ 125,983	10,828	$ 394,083	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,318	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (61,043))	540,564		3
4	Supply Inventory (priced at)	5,229		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,612		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 550,723	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,050		13
14	Buildings, at Historical Cost	2,666,745		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	751,363		16
17	Accumulated Depreciation (book methods)	(2,746,508)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 725,650	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,276,373	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,345	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,040		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,949		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	44,975		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 321,309	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,211		39
40	Mortgage Payable	420,194		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 700,405	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,021,714	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 254,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,276,373	$	48

***(See instructions.)**

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,143,461	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,143,461	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,892	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 412,892	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(1,301,694)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,301,694)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 254,659	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,553,127	1
2	Discounts and Allowances for all Levels	(421,265)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,131,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	624,865	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 624,865	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,649	12
13	Barber and Beauty Care	17,501	13
14	Non-Patient Meals	1,242	14
15	Telephone, Television and Radio	(286)	15
16	Rental of Facility Space		16
17	Sale of Drugs	132,978	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,238	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,906	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 182,228	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,641	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,641	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	(1)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,940,595	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	704,339	31
32	Health Care	1,963,714	32
33	General Administration	1,205,907	33
	B. Capital Expense		
34	Ownership	390,037	34
	C. Ancillary Expense		
35	Special Cost Centers	263,706	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,527,703	40
41	**Income before Income Taxes (line 30 minus line 40)****	412,892	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 412,892	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,153	4,547	$ 99,678	$ 21.92	1
2	Assistant Director of Nursing	648	709	15,178	21.41	2
3	Registered Nurses	10,337	11,317	235,862	20.84	3
4	Licensed Practical Nurses	17,106	18,728	274,726	14.67	4
5	Nurse Aides & Orderlies	65,377	71,577	673,201	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,279	10,221	243,034	23.78	7
8	Rehab/Therapy Aides					8
9	Activity Director	9,296	10,210	88,968	8.71	9
10	Activity Assistants					10
11	Social Service Workers	3,221	3,383	48,862	14.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,562	20,370	179,586	8.82	15
16	Dishwashers					16
17	Maintenance Workers	2,462	2,699	34,495	12.78	17
18	Housekeepers	9,021	9,901	86,208	8.71	18
19	Laundry	3,712	4,071	35,673	8.76	19
20	Administrator	2,577	2,080	66,101	31.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,509	14,875	204,981	13.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,785	3,056	35,192	11.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,045	187,744	$ 2,321,745 *	$ 12.37	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	6,800	5,9,3	36
37	Medical Records Consultant	Monthly	250	5,10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,245	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,295		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	140	$ 2,925	5,10,3	50
51	Licensed Practical Nurses	309	4,532	5,10,3	51
52	Nurse Aides	647	6,090	5,10,3	52
53	TOTAL (lines 50 - 52)	1,096	$ 13,547		53

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terra Dillon	Administrator	0	$ 44,612
Doug Harridge	Administrator	0	21,489
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,101

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 258,523
TOTAL (agree to Schedule V, line 17, col. 3)	$ 258,523
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal fees	$ 318
Jo Samuel (Housekeeping)	Environmental Consul.	70
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 388

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,828
Unemployment Compensation Insurance	25,262
FICA Taxes	162,670
Employee Health Insurance	141,228
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	9,377
Payroll Overhead Allocated	0
401K / SMSP Match	15,006
Other Employee Benefits	2,417
Employee Vaccination	2,378
Home Office Allocation	8,576
TOTAL (agree to Schedule V, line 22, col.8)	$ 397,742

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 550
Advertising: Employee Recruitment	22,633
Health Care Worker Background Check	256
(Indicate # of checks performed 13)	
Dues & Subscriptions	2,830
Association Dues	4,838
Advertising	17,244
Public Relations	15
Less: NonAllowable Assoc Dues	(1,515)
Less: Public Relations Expense	(15)
Non-allowable advertising	(17,244)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,592

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	14,136
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,136

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MANORCARE AT CHAMPAIGN # 0027581 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MANORCARE AT CHAMPAIGN **#** 0027581 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,838**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,660** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,242)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.